

Testimony for the Governor's Public Employee Post-Employment Benefits Commission

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May 31, 2007

First, I would like to thank the Commissioners for inviting me here to speak today.

I will talk about cost trends in retiree health benefits, how private sector employers are responding to those trends, and the implications for the public. I will conclude with a discussion of steps that could be taken in the current health policy reform debates to control health premium inflation.

As you are all aware, for all but four years of the last two decades, health premium costs have risen faster than workers' earnings and overall inflation. Premium increases reached double digits in the years 2001 through 2004. Over the last two years, increases have moderated, but were still more than twice the rate of inflation. Most experts believe that we are in the downturn in the insurance underwriting cycle and that rate of premium costs increases will continue to slow over the short run. Growth in retiree health premiums has tracked or exceeded the general rise in health premium costs and is the central factor in the increase in retiree health benefit obligations.^{1 2 3}

Faced with rising health premium costs, private employers have responded in three basic ways:⁴

1. The most common response of private employers has been to raise retirees' share of premiums. Three-quarters of private sector firms with retiree health benefits have increased premiums for retiree care for those under 65 and 58% have raised premiums for Medicare-eligible retirees, according to the Kaiser/Hewitt 2006 Survey of Retiree Health Benefits.
2. The second response is to increase cost-sharing requirements through higher deductibles and greater co-insurance. One-third of private sector firms surveyed raised cost-sharing requirements for those under 65, and nearly one-quarter of firms raised cost-sharing requirements for retirees over 65.
3. The third response has been restricting eligibility. Between 1988 and 2003 the share of large private sector employers offering retiree coverage dropped by half, from two-thirds

¹ "Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits," December 2006.

² Hill, Elizabeth G., "Retiree Healthcare: A Growing Cost for Government," The Legislative Analyst's Office, February 17, 2006. http://www.lao.ca.gov/2006/ret_hlthcare/retiree_healthcare_021706.pdf

³ Buchmueller, T., Johnson, R., and Lo Sasso, A., "Trends in Retiree Health Insurance. 1997-2003, in *Health Affairs*, Vol. 25, No. 6, 2006.

⁴ "Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits," December 2006.

to slightly over one-third. This has happened primarily through eliminating coverage for new workers and business churning, with new firms less likely to offer coverage.

The reduction in retiree health benefits is undermining the financial and health security of retirees. It is also having important impacts on public finances.

Increasing retirees' share of premiums can lead to financial hardship and affect take-up rates of coverage.⁵ Higher deductibles, co-pays and co-insurance reduce utilization. In the current health care debates some are arguing that shifting financial responsibility onto consumers is a good way to control costs. The research is clear that with higher out-of-pocket costs, consumers forgo care—but they forgo clinically appropriate and unnecessary care in equal measure. This is especially problematic for older Americans who are in the greatest need of preventive care and are most likely to have chronic health conditions that will tend to worsen over time. For example, the level of cost-sharing for prescription drugs for seniors has a significant impact on skipping needed medication.⁶

The greatest impact is on those who retire before the age of 65 and lack retiree coverage through their previous employment. Job-based coverage for Americans under age 65 in general fell by five percent points between 2001 and 2005.⁷ The fastest-growing group without health insurance in America is men over fifty.

The median retirement age in California is 62, three years before Medicare eligibility kicks in. Workers often retire earlier than they had planned due to health-related causes or job displacement. According to a study by the Commonwealth Foundation, one in five people between 62 and 64 reports having health problems that limit their ability to work, and one in four reports they are in fair or poor health.⁸ Black and Hispanic workers are particularly vulnerable to losing health insurance in the pre-Medicare years, as they experience higher rates of involuntary job loss during those years than their white cohorts of similar socio-economic status.⁹ Across the board, older displaced workers are significantly less likely to be insured than their working counterparts one year or more after losing their jobs.¹⁰ While COBRA is available for 18 months after retirement at 102% of group rates, it is at full cost to the worker. Once COBRA expires, coverage for late-middle-age and elderly Americans can be prohibitively expensive on the

⁵ Buchmueller, T., and Ohri, S., "Health Insurance Take-up by the Near-Elderly," Working Paper 11951, National Bureau of Economic Research, January 2006.

⁶ Gibson, T., Ozminkowski, R., Goetzel, R., "The Effects of Prescription Drug Cost Sharing: A Review of the Evidence," *The American Journal of Managed Care*, Vol. 11, Number 11, pp. 730-740, November 2005.

⁷ Dube, A., Jacobs, K., Muller, S., Brownstein, R., Ellis-Lamkins, P., "Declining Job-Based Health Coverage in the United States and California: A Crisis for Working Families," UC Berkeley Labor Center and Working Partnerships USA, January 2006.

⁸ Short, P. F., Shea, D. G., and Powell, M. P., "Health Insurance on the Way to Medicare: Is Special Government Assistance Warranted?," *The Commonwealth Fund*, publication number 457, p. vii.

⁹ Flippen, C., and Tienda, M., "Pathways to Retirement: patterns of labor force participation and labor market exit among pre-retirement population by race, Hispanic origin, and sex," *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, Vol. 55, Issue 1 S14—S27, 2000.

¹⁰ Lin, E., "Health Insurance Coverage and Reemployment Outcomes Among Older Displaced Workers," *Contemporary Economic Policy* 2005 23(4):529-544.

individual market without community rating, and those with chronic health problems are routinely denied coverage.¹¹

Even small breaks in coverage between leaving work and eligibility for Medicare have been shown to have long-term health consequences. Those without health insurance for any period of time are less likely to have access to preventive services, to have a regular source of care, to receive timely care for acute medical problems, and to take medications for chronic illness both during the time they are uninsured and in the years following, even when they finally gain access to Medicare. Older adults in late middle age, defined as those older than 51, who lack health insurance for as little as two years are more likely to experience a significant decline in health or to die. At least one quarter of these older adults will be uninsured at some point during the years preceding Medicare eligibility.^{12 13 14 15}

Along with the health care consequences, losing health benefits can have a major financial impact on retirees. It seems obvious that older adults and their spouses would face increasing health-related costs than younger adults, but the fact is that costs grow precipitously in the late-middle-age years as chronic conditions such as diabetes, heart disease, and high blood pressure become common. Male workers older than 55 spend five times the amount on health care spent by male workers in their twenties, and twice the amount spent by male workers between 30 and 54.¹⁶ Even small increases in out-of-pocket costs during this period, not to mention catastrophic spending, can have an impact on retirement savings. Traditionally, employer-sponsored retiree plans are more generous in providing prescription coverage and out-of-pocket spending caps than other sources of coverage such as private plans.¹⁷ As availability and quality of employer-provided retiree plans decline, we can expect to see the financial impacts grow.

Health costs for the uninsured are not only born by individual consumers. Costs of care are also shifted onto the state and other players. Those who are uninsured delay care until problems become acute, then rely on safety net programs and uncompensated care. Much of this cost is born by the state and federal government, as well as by anyone who pays for health care insurance. The New America Foundation estimates that the cost-shift from uncompensated care onto health providers accounts for 10% of premium prices.¹⁸ As with the increase in premium

¹¹ Neuman, P., "The State of Retiree Health Benefits: Historical Trends and Future Uncertainties," Testimony at a Hearing of the Special Committee on Aging, United States Senate, May 17, 2004.

¹² Sudano, J., and Baker, D., "Intermittent Lack of Health Insurance Coverage and Use of Preventive Services," *American Journal of Public Health*, Vol. 93, No. 1, pp. 130-137, January 2003.

¹³ Baker, D., and Sudano, J., "Health Insurance Coverage During the Years Preceding Medicare Eligibility," original investigation, *American Medical Association*, 2005, (reprinted) *Arch Intern Med.*, 2005; 165:770-776.

¹⁴ Baker, D., Sudano, J., Albert, J., Borawski, E., and Dor, A., "Loss of health insurance and the risk for a decline in self-reported health and physical functioning, 1992-2002," *Medical Care*, vol. 44, pp. 277-282, 2006.

¹⁵ Rust, J., Buchinsky, Moshe, Benitez-Silva, H., Boz, E., Nichols, J., Roy, S., and Tristao, I., "Health Status, Insurance, and Expenditures in the Transition from Work to Retirement," Working Paper funded by Economic Research Initiative on the Uninsured, July 2005.

¹⁶ Monheit, A., Vistnes, J., and Eisenberg, J., "Moving to Medicare: Trends in the Health Insurance Status of Near-Elderly Workers, 1987-1996," *Health Affairs*, Vol. 20, Number 2, March/April 2001.

¹⁷ Neuman, P., "The State of Retiree Health Benefits: Historical Trends and Future Uncertainties," Testimony at a Hearing of the Special Committee on Aging, United States Senate, May 17, 2004.

¹⁸ Nichols, L., and Harbage, P., "Estimating the 'Hidden Tax' on Insured Californians Due to the Care Needed and Received by the Uninsured," Policy Memo of the New America Foundation, May 2007.

costs, these problems mirror the costs borne on behalf of the uninsured in general, but are made more acute by the greater likelihood of uninsured people who are in late middle age to have chronic health conditions.

Finally, when workers do not have retiree health coverage, they are significantly more likely to stay in their job longer regardless of whether or not that job continues to be a good skill fit, either through reductions in the workers physical capacity, or through technological change that shifts the skills needed for the position. Without retiree coverage, workers are discouraged from changing jobs to find fits that better match their current capacities if those jobs do not offer comparable health benefits.¹⁹ The resulting job-lock harms workers who might seek a better job fit elsewhere, and also reduces productivity.

Declining retiree coverage has an additional impact on spouses, particularly women. Women in dual-earner households are less likely than their spouses to be offered health coverage, and wives are, on average, 3-4 years younger than their husbands. With a median retirement age of 62, this potentially creates a gap in quality coverage for her or as many as 7-8 additional years of work for the husband to maintain his wife's benefits, until she can claim Medicare coverage.²⁰

Most of the declines in private sector retiree health benefits will be felt over time as a greater number of older workers are left without coverage. Without changes in public policy, these trends will have negative consequences for the health of older Americans and can be expected to result in greater health costs for the state and federal governments. For the state government to follow the lead of the private sector in this regard would be largely self-defeating.

The retiree health crisis in the public sector cannot be separated from the health crisis in the state and nation overall. Had the federal government lowered the Medicare age when it was proposed in 1998, we would be having a very different discussion today.

There is an opportunity in California this year to address some of the issues that effect health costs. The health care reform proposals under discussion in Sacramento all have important implications for retiree health care and health premium costs.

Senator Kuhl's proposal, of course, would replace the need for retiree benefits in the state by providing universal access to care. Each of the other major proposals would leave our job-based health care financing system intact, with important modifications.

Each of the reform proposals would expand access to care and reduce the cost shift of uncompensated care onto health premiums. Each of the proposals would promote greater emphasis on prevention, wellness and chronic disease management, and expansion of health information technology to reduce medical errors and improve quality. These measures are not only important for the health of the state residents; they could serve to help slow the rate of growth of health premiums in the state, including retiree health premiums.

¹⁹ Fronstin, P, "Retirement patterns and employee benefits: do benefits matter?," *The Gerontologist*, Vol. 39, Issue 1, pp. 37-47, 1999.

²⁰ Schimmel, J., "Men with Health Insurance and the Women Who Love Them: the Effect of a Husband's Retirement on His Wife's Health Insurance Coverage," University of Michigan Retirement Research Center Working Paper, WP 2006-131, 2006.

Consumer organizations have proposed additional measures that could help bring premium increases more in check. Proposals include:

- Requiring greater transparency to health care purchasers from providers on cost, utilization and quality outcomes in order to enable purchasers to make more informed decisions, help to ensure that consumers receive appropriate care, and reduce high cost care with poor outcomes;
- Increasing public oversight of health premiums and their component costs to help smooth the curve on premium increases and avoid the shocks of recent years; and
- Joining the newly proposed health pools with other state purchasers in order to maximize the states purchasing power for prescription drugs.

These and other proposals under debate in California will have important impacts on retiree health benefits and health premium prices.

In the final analysis, the problem of retiree healthcare in the state cannot be separated from the broader health care crisis in the state and nation. Private-sector reductions in retiree healthcare will result in negative outcomes in our retirees' health and well-being, and will shift costs to the state and federal governments as well as other health care consumers. Action will be needed by the state on a policy level both to improve health care access for older adults and to control the rate of growth in health premium costs.